

Rights, risks and limits to freedom

Principles and good practice
guidance for practitioners
considering restraint in
residential care settings

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We believe that restraint should be seen as a ‘last resort’, where there is absolutely no alternative.

Section 1

Restraint and limits to freedom – what does it mean?

In its broadest sense, restraint is taking place when the planned or unplanned, conscious or unconscious actions of care staff prevent a resident or patient from doing what he or she wishes to do and as a result places limits on his or her freedom.

Is there ever any justification for the use of restraint?

Think how you would feel if you were prevented from getting out of your chair or had your movements restricted in some way. Being restrained can be frightening, potentially dangerous and undignified. We believe that restraint should be seen as a ‘last resort’ intervention. It should be used only where there is absolutely no alternative that would reduce an identified, specific risk to the person concerned to an acceptable level. We also think that staff must always be vigilant against unnecessarily restricting the freedom of their clients in other less specific ways.

Many actions by care staff, conscious and unconscious, can unnecessarily limit the freedom of the people they are looking after. Often these are not in the interests of the individual but in the interests of the care home, hospital or other setting in which the person is being cared for.

The justification given for the use of restraint is to reduce risk to the individual concerned. As a rule we all have the right to take risks in our lives, risk taking is a part of normal life. Any activity has some degree of risk attached to it, but that risk can change according to our capabilities. There is hardly any risk to a fit and able adolescent when he or she jumps out of bed, but the risk of falling could be high for an older person who has problems with moving around. So, if people have a right to take risks how do care staff strike the right balance between freedom and risk of harm and when should they intervene? Our guidance aims to help with these difficult decisions by providing general guidance and setting out questions that should be considered before embarking on the use of restraint.

We think that as a rule the use of restraint, without the consent of the individual concerned, should only be considered where that person has a significant degree of diminished capacity to understand the risk that he or she is putting themselves in. In addition, the risk must be of a degree that justifies such a major intervention in that person’s life.

1.1 Recognising restraint

In situations where a person is being cared for by others, some actions can clearly be recognised as restraint.

These can include any direct interference with the bodily movement of a resident, whether by the direct action of another person or by mechanical means; any physical or electronic barriers to freedom of movement in a care setting; and the use of drug treatment to limit physical movement by sedation.

However, 'softer' methods of restraint such as verbal control, psychological pressure or social exclusion can have just as restraining an effect on a person's behaviour as direct physical intervention. Unfriendly, brusque or bullying attitudes by staff do not encourage residents or patients to ask for help to move to another room, or go to the toilet and can be seen as having a restraining effect on the freedom of movement of the resident concerned. Not providing someone with a walking aid, not providing assistance with using stairs, doors that are difficult to open are, in effect, restraint by default.

Staff must be sensitive to the effects of their actions. Tightly tucking in a resident's bedclothes in a way that restricts movement, or positioning furniture to prevent a door being opened, might be done with good intentions but is in effect restraint. It is also potentially dangerous and frightening to the resident concerned. The attitudes and training of staff and the ethos of care in any setting must ensure that:

- care is given in such a way as to recognise what are acceptable risks;
- that restraint is minimised; and
- that restraint is used only when there is a clear and unequivocal benefit to the resident.

Financial restraints are not considered in this guidance but clearly the control of a resident's money could have a restraining effect on their freedom of action and liberty. Where a resident's access to money is being controlled to limit their freedom of action, then full consideration must be given to the relevant provisions of the Adults with Incapacity (Scotland) Act 2000.

1.2 Who is at risk?

Staff in care homes or hospitals do not look after individual people in isolation. There can be many competing pressures on staff to generally 'keep things safe' while carrying out the day-to-day tasks necessary to keep a care home or ward running. If a resident who is at risk of falling is prevented from, or not assisted in, being mobile it may be easier for care staff but is clearly not in that person's interests. Inactivity is well recognised as having adverse effects on the physical and mental well being of residents of care homes and hospitals. Put simply – sitting still is bad for your health. Activity and physical fitness may reduce the risk of falling. When assessments of risk are made as part of a resident's care plan it is the risk to the resident that is paramount, not the risk to the care home or hospital in which they are being cared for.

1.3 Dilemmas for care staff – differences of opinion

Staff face a difficult dilemma when they are attempting to carry out their duty of care and the person concerned is confused, fearful and refusing their help. What degree of intervention is appropriate to make sure that the resident is physically well cared for and appropriately dressed? Is it appropriate to physically restrain someone to make them have a bath or to change their clothes? Where a resident has fallen and their relatives are insisting that he or she be prevented from freely walking about, staff can feel under considerable pressure to eliminate all risk. Ultimately, there is a balance to be struck between the risks arising from restraint in any form and the risk to the resident of not intervening. This guidance points to the importance of careful assessment to understand why someone is behaving in a particular way, of recognising what the risks actually are and arriving at appropriate interventions in an open and transparent way that has involved all interested parties.

1.4 Environmental design

The design of a residential care setting can have a significant influence on the behaviour of people affected by dementia. A well designed facility can aid orientation and reduce the kinds of behaviour that lead to interventions that restrict the freedom of residents. National guidance on the management of patients with dementia published by SIGN provides guidance on non-pharmacological interventions including environmental design. The Dementia Services Development Centre at Stirling University produces a number of publications on the design of dementia friendly environments.

1.5 Legislation and regulation

People using restraint in care settings need to make sure that what they are doing complies with the law and relevant care regulations. More detail on the legal background in Scotland relating to the use of restraint can be found in Appendix 1.

The Adults with Incapacity (Scotland) Act 2000 provides a legal framework for intervening in the affairs of adults with incapacity. The Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision for the treatment of persons with a mental disorder. Both of these pieces of legislation provide sets of principles relating to their operation. It is likely that the use of restraint will be considered only in the care of persons with some degree of impaired capacity and/or impaired judgment arising from mental disorder. The Commission therefore believes that the principles of the 2000 and 2003 Acts should be seen as the bedrock of our guidance on restraint.

The Scottish Commission for the Regulation of Care (the Care Commission) is the body that registers and inspects care homes in Scotland using the National Care Standards. These make specific reference to risks, safety of residents and restraint. It is our intention that this guidance be used by care providers to support the National Care Standards by providing general principles and more detailed comment on specific methods of restraint.

1.5.1 Principles of the Adults With Incapacity (Scotland) Act 2000

Anyone planning an intervention under this law must ensure the following principles are upheld:

Principle 1

The intervention must be of benefit to the individual.

Principle 2

The intervention must be the least restrictive in relation to the person's freedom in order to achieve the desired benefit.

Principle 3

Interventions should take account of the past and present wishes of the adult.

Principle 4

Interventions take account of the views of relevant other parties.

Principle 5

Interventions should encourage the adult to use existing skills and develop new skills.

1.5.2 Principles of the Mental Health (Care and Treatment) (Scotland) Act 2003

Anyone who is providing treatment under this law must take into account:

- The person's past and present wishes about their care and treatment
- The care and treatment that will be of most benefit
- The range of options available for care and treatment of the individual
- The person's individual abilities and background
- The person's age, gender, sexual orientation, religion, racial origin or membership of any ethnic group.

People giving care should also make sure that:

- Any restrictions on a person's freedom are the least necessary.
- The person being treated under the act shouldn't be treated any less favourably than anyone else being treated for a mental illness, or other mental disorder.
- Carer's needs are taken into account.
- The person being treated is getting services that are right for them.
- When a person is no longer receiving compulsory treatment, he or she should still continue to get care and treatment if it is needed.
- If the person being treated is under 18, his or her welfare is of the highest priority.

Section 2

Using this guidance

This guidance cannot give answers to every situation residents and care staff find themselves in. What this guidance aims to do is to help guide thinking on the use of restraint and encourage all care staff to consider their actions and the impact that those actions may have on the people they are caring for. Staff will normally want to do what is best for those in their care. Environmental, organisational and institutional pressures however, combined with poor support and lack of training, can lead to insufficient attention being paid to the needs of residents and patients. When assessing risks and considering interventions, care providers must never forget that it is a person, with their own life experiences and their own wishes, who is at the heart of the decision.

This guidance sets out a number of general principles that the Commission believes apply to the use of restraint in any setting. These general principles should be taken into account when restraint is being

considered in the care of any person who has a mental learning difficulty, dementia or other mental disorder. The guidance also includes sections on particular types of restraint and interventions that can lead to the freedom of movement and liberty of residents being limited in some way.

These sections should only be considered in the light of the general principles. The guidance is intended to help care providers in the preparation of their own policies on restraint and should be considered alongside the standards produced in Scotland by the National Care Standards Committee.

Section 3

General principles

The following general principles are applicable to all situations in which restraint of a mentally impaired resident is contemplated.

3.1 Considering the use of restraint

People who are in hospital, in care homes, or receiving care in the community retain their full human rights, unless these have been restricted by a legal process and then only to the extent allowed by the law.

3.1.1 Residents should always be involved in any discussion of restraint, no matter how disabled they are. *Almost all residents will have some ability to express, verbally or otherwise (e.g. by gesture or by signing), their views about how they wish to be treated, or may have expressed them in the past. To the extent to which it is possible and reasonable, the resident's informed, free and full consent to any restraining action should be obtained. Any relatives, advocates, welfare attorneys or guardians should be*

Life is never risk-free. Some degree of risk-taking is an essential part of good care.

involved in the discussions. In all cases some explanation should be given, at a level the person can understand.

3.1.2 Self-determination and freedom of choice and movement should be paramount, unless there are compelling reasons why this should not be so.

3.1.3 Life is never risk-free, risk is a part of everyone's existence. Some degree of risk-taking is an essential part of good care. Each care home or hospital should have an explicit policy which determines the balance between residents' personal autonomy and staff's duty to care. The principal aim of any policy should be to avoid restraint wherever possible. *This should be fully discussed by all concerned. Residents and next-of-kin, welfare attorneys or guardians, legal or other representatives such as advocacy workers, as well as managers and staff need to be fully informed of these policies. They may, for example, be briefly explained in descriptive leaflets, but should be available in full written form. Policies should emphasise the necessity of some degree of risk-taking to allow freedom of action*

and movement, respect for autonomy, privacy and the dignity of the individual.

3.1.4 Restraint should never be used to cover any deficiency of service, lack of professional skill, or defects in the environment.

Initial assessment

3.1.5 Assessment of any risks should be a normal part of care planning for each resident with mental impairment. These care plans should include strategies to anticipate and manage future risks.

3.1.6 Residents should expect that any care home or hospital should accommodate his or her normal level of physical activity. Establishing that level of activity is a key aspect of any assessment of risk.

3.1.7 When an individual resident's behaviour is such that restraint is contemplated, the first step should be to assess why the person is acting in the way that is causing concern. *This should lead to a full re-assessment of the person's problems, including in most cases a medical assessment. Factors such as physical illness, discomfort or pain, side effects of drugs,*

psychological distress perhaps arising from life events such as loss and bereavement, poor relationships and incompatibility between the person and their carers, other resident or environment all need to be considered. Behaviour problems secondary to psychiatric illness or epilepsy may be particularly difficult to assess and require specialist input.

3.1.8 Relevant outsiders to a care home or ward should be consulted with and informed about any intended restraint of a resident. *For example, in a care home this could involve any or all of the relatives, managers, general practitioners, social workers, community psychiatric nurses. Restraint procedures should be discussed with the local Care Commission's Registration and Inspection Team. The relevant National Care Standards for Care Homes must be complied with. Hospitals need clear procedures for informing managers of individual cases where restraint is considered, as well as involving managers in the formulation of policies on restraint. Policies relating*

to personal autonomy and restraint should be considered by commissioners of services as part of the process of contracting for a service.

3.1.9 The assessment of the resident's behaviour should include full consideration of the influence of that resident's ethnic and cultural background and any consequent communication difficulties that staff might have. *Staff should have training in the provision of care that is culturally appropriate for residents from an ethnic minority background. Communication difficulties and/or the provision of culturally inappropriate care could increase the likelihood of confusion and adversely affect behaviour.*

3.1.10 Assessment of a possible need for restraint should always take account of potential distress and increased risk caused by the restraint itself. There are considerable health and safety issues associated with the use of restraint which must be considered fully. *Restraint can increase the level of risk, or add new risks (e.g. expose a resident to*

hazards created by other residents' behaviour which they cannot avoid, or confine him or her in such a way that attempts to escape are potentially harmful).

3.1.11 Assessment of a possible need for restraint should include an assessment of any possible benefits to the individual, whose interests should be paramount. *Restraint may, on occasion, by avoiding risks of injury, enhance the freedom of an individual and will sometimes enhance the freedom of other residents by reducing risks to them.*

3.1.12 It is highly undesirable to restrain a resident in a way which causes greater distress than the original problem. *Multi-disciplinary discussion should attempt to predict and understand how the resident is likely to feel if their movements are limited. Any reduction in social contact caused by restraint may, in itself, be distressing to the resident, as may the social stigma of 'needing' restraint. It is recognised that some people with learning disability may require brief removal from a situation which they have found over stimulating or distressing.*

This diversion to a low-stimulus environment should be clearly distinguished from 'time-out' (i.e. a carefully planned intervention which is part of a behaviour modification programme), which should never be instituted without specialist consultation and monitoring.

Acceptable risk

3.1.13 If no remediable cause is found, the next step is to assess the degree of risk inherent in the resident being unrestrained, remembering that people are entitled to take risks. Only if that risk is unacceptable should further discussion of restraint proceed.

3.1.14 Discussion of the risks that are leading to the consideration of the restraint of an individual, should involve all relevant members of staff on a multi-disciplinary basis. This discussion should include the person in direct charge of the ward or care home and significant relatives, advocates, welfare attorneys, guardians or other representatives.

Restraint must never be used as a threat in order to control behaviour.

Alternatives

3.1.15 Alternatives to physical restraint should always be considered first. *These may include medical, psychological or other treatments, and/or modifications of observation policy, care regimes, the resident's activities, or even of buildings. The assessment should pay careful attention to identifying any existing intervention, or aspect of the care environment, that may be a cause of the behaviour for which restraint is being considered.*

Applying restraint

3.1.16 If restraint is considered necessary it should be the minimum required to deal with the agreed risk, applied for the minimum possible time.

3.1.17 On each occasion when restraint is applied, a careful explanation should be given to the resident, in terms which he or she can understand. *This should include the reasons for the restraint, the way it will be applied, the likely duration, and which staff will be available during the period of restraint. Wherever*

practicable and appropriate, explanations should be oral, in writing or with augmented communication aids i.e. symbols.

3.1.18 Restraint must never be used as a threat in an attempt to control behaviour seen as undesirable by staff.

3.1.19 During any period where a resident's movements are subject to restraint one or more staff members must be in direct, continuing visual and verbal contact with the resident.

3.1.20 If it is likely that someone may need regular or repeated use of restraint, legal provisions should be seriously considered (Welfare Guardianship under the Adults with Incapacity (Scotland) Act 2000 or compulsory powers under the Mental Health (Care and Treatment) (Scotland) Act 2003).

3.1.21 Restraint procedures should only be used by staff who have been fully trained in non-restrictive methods of care and also in the methods of restraint. A carer properly trained in restraint procedures should be less likely to feel the need to use them. *Information on training*

of staff should be available to service users and relatives and should be examined as part of any inspection of the service. Restraint should, where possible, be based on well researched and recognised practice.

Continuous re-assessment

3.1.22 Any restraint used must be a considered part of the resident's individual care plan. Its use should be based on a multi-disciplinary discussion, which should be fully described in the care plan, together with the decisions taken and the arrangements for regular reviews within specified periods of time.

3.1.23 Each episode of restraint must be recorded in a clear standard format and must include a record of the time for which the restraint was applied.

Unplanned restraint

3.1.24 If restraint has been applied in an emergency, without time to explain its use, it is most important that a full explanation and support is offered to the resident as soon as reasonably possible after the event. *After any emergency restraint, there should be a*

review of the circumstances which led to the restraint and reconsideration of the resident's care plan.

3.1.25 All episodes of unplanned 'emergency' restraint must be recorded in the resident's care plan and in the care home/ward's incident reporting procedures.

Monitoring the use of restraint

3.1.26 Managers of care homes or hospitals should audit patterns of restraint use and relevant incidents or accidents. Such audit should inform local policy and practice and must be recorded.

3.2 Direct physical restraint

The following sections refer to the various types of restraint which may be considered in an individual case. In each section only the specific considerations of the particular method of restraint under discussion are described.

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

3.2.1 Definition

The actual or threatened laying of hands on a person to stop him or her from either embarking on some movement or activity, or following it through. The grounds for intervention are that the person's action is likely to lead to hurt or harm to the person or others, or prevent necessary help being given.

3.2.2 Compulsory powers and the law

The Mental Health (Care and Treatment) (Scotland) Act 2003 authorises the use of compulsory measures where a person's mental disorder makes him or her a risk to his or herself or to others and where the person's ability to make decisions about

treatment is significantly impaired. The Adults With Incapacity (Scotland) Act 2000 provides a framework for taking medical, welfare and financial decisions for adults who are unable, because of mental disorder, to make such decisions themselves. The law and restraint is discussed in more detail in the legal section of this document.

3.2.3 Duty to care

It is generally accepted that nurses and other care staff have the same rights as any other citizen in using minimum restraint necessary, either to prevent an offence or to save someone from hurt. The duty to care brings additional responsibilities. Staff are expected to behave as professionals, neither neglecting their charges nor putting them at unnecessary risk.

3.2.4 Guidelines

Direct physical restraint must only be applied under clear guidelines with careful monitoring and review. Best practice would be to have an individual prescriptive plan, accessible to outside observers including relatives and inspection teams. Relatives need to know that

risks cannot be eliminated, even when a person is in hospital or residential care, and that quality of life factors and the expressed wishes of people may require that risks are taken. Policies on restraint should always be discussed with individual residents where possible, and certainly with the immediate family when available.

3.2.5 Restraint in non-health settings

It is sometimes felt, that what might be regarded as acceptable management by qualified nurses, is not necessarily so when applied by persons with different or lesser training and qualifications. Care staff in homes and the community should recognise however, that their duty to care effectively for their charges and not put them at unnecessary risk is not greatly different from the duty of nursing staff to care for informal residents.

3.2.6 Training

Restraint techniques require to be taught effectively with regular refresher courses. Incorrect use of restraint techniques can lead to injuries. Recognised training

in such techniques should therefore be an essential part of all nurse and care staff education, to ensure that the least restrictive methods are always used. Particular attention should be paid to the risk of postural asphyxiation associated with prone restraint.

3.3 Direct mechanical restraint

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

3.3.1 Definition

The commonest form of direct mechanical restraint in use is the restraining chair and/or belts for people who are mobile, or think they are mobile, but are liable to fall or otherwise injure themselves when they walk or attempt to walk. Other forms of mechanical restraint sometimes considered include limb restrictions, for those who repeatedly harm themselves, and cot sides, or secure sleeping bags for those who are restless at night.

3.3.2 Normal activity

Staff should know how active a resident normally is, what form that activity normally takes and what time of day is their most active. Information from relatives or other carers is essential in building a picture of the resident's usual behaviour and likes and dislikes. The care plan should include provision for that normal activity.

3.3.3 Assessment

All restless or poorly mobile residents should have a full physical examination to look for causes and identify effective treatment where possible. Medication should be reviewed, and reduced, increased or changed where appropriate.

3.3.4 Alternatives

In all cases, alternatives to mechanical restraint should be considered first. These include:

- increase in supervised exercise time
- redeployment or increasing staff for observation and supervision
- change in the pattern of rest periods in bed
- provision of engrossing seated activities for the individual or for a group
- imaginative use of diversional or occupational therapy
- use of special environments.

3.3.5 Exercise

Active exercise may improve mobility, reduce frustration and distress caused by lack of activity and boredom, and consequently reduce risk.

3.3.6 Staffing

Almost all the consequences of restlessness and associated risk could be solved by increased staffing levels. Where one resident is at considerable risk, or a number of residents are at risk, staffing levels should be reviewed.

3.3.7 Environment

Environmental factors should be considered including:

- temperature of the ward or home
- distressing noise levels, including 'background' music and 'background' TV
- poor lighting
- restrictive, or oppressive, spaces or decor
- overcrowding
- ease of observation.

3.3.8 Safety

The safety of the environment is also important, avoiding:

- big open spaces
- steps and stairs
- things to trip over
- hard and sharp edges
- hard or rough floors
- slippery floors.

3.3.9 Special environments

Special environments, such as Snoezelen techniques and rooms, or 'soft' environments need further research, perhaps leading to wider use.

3.3.10 Safety clothing

It is reasonable to consider the use of padded clothing, knee pads, hip protectors, helmets and other safety devices for residents who like to walk but are in danger of falling. Such safety clothing can in a suitable case enhance freedom, but the possible stigma to the wearer should be carefully taken into account.

3.3.11 Use of night attire to restrict movement

It is never acceptable to use night attire with the purpose of preventing a resident from leaving the building. There may be residents who choose to wear less formal clothing, and some who at particular times of day like to wear night attire. However, this should not be imposed on residents. It is potentially stigmatising and confusing.

3.3.12 Comfort

Any chair that has the effect of restraining a resident should look, and feel, comfortable to the person. It must therefore be individually fitted for his or her requirements. It should allow a considerable degree of freedom of movement. It should allow the resident to engage in eating and drinking and, if possible, in other activities such as reading, or manipulating objects with their hands for diversion. Similarly, a chair should not inhibit a resident from being in contact with other people. It should never be a form of seclusion. Individual care plans should set out clearly what is an acceptable length of time for a resident to remain seated without an offer of assistance to exercise or go to the toilet.

Restraining chairs should not be indiscriminately used in hospital wards or care homes.

3.3.13 Physical disability

Some residents may have a physical disability as well as mental impairment. Individuals with spasticity or spinal deformity may require a snug fitting chair with special cushions, pommels and pelvic belts to ensure a good seated position. This may, in turn, improve comfort, reduce the risk of contractures and deformities, and improve independence. There are therefore some situations in which a belt can be used as an aid to comfortable seating and safety.

3.3.14 Trays

Trays fixed to chairs should not be used for the primary purpose of restraining a resident. However, trays fixed with Velcro can give a useful surface for the resident to eat from, read at or engage in other selective activities. Trays are likely to feel restrictive and should not be used for extended periods of time.

3.3.15 Limb restrictions

The tying of limbs, or the tying of the resident's body into their chair, will inevitably feel very restrictive to the resident and should in

almost no circumstances be considered. There will always be alternatives to consider.

The only possible rare exception would be where the resident was specifically in danger of damaging one area of the body (e.g. by severe picking or scratching, or because he or she required intravenous infusion) and it was believed that a temporary use of restraint would result in a longer-term reduction in self-harming behaviour. Special nursing is always preferable to this form of physical restraint.

3.3.16 The use of bed rails (cot sides) and restraint in bed

Some residents may be restless at night and the use of bed rails or other types of restraint such as 'cocoons' may be contemplated. Again, causes of restlessness and alternative solutions must be sought. The resident's perceptions and the possible risks of trying to get out of bed with the bed rails in place should be considered. It is highly likely that the use of bed rails will increase the risk of injury from falling, as the resident must climb

It is completely unacceptable that the use of restraint increases the overall risk to a resident.

higher to get past the obstruction. The alternative of putting the resident's mattress on the floor may be perfectly reasonable, if it can be done in a way which is not demeaning to the resident and does not adversely affect comfort.

3.3.17 Risks from restraint

Accidents and deaths have arisen from the poorly planned and inappropriate use of restraint. The risks to the resident or patient arising from the use of restraint must be considered. It is completely unacceptable for the use of restraint to increase the overall risk to a resident.

3.3.18 Observation

A person who is the subject of any mechanical restraint should never be left unobserved. This is essential because the person would probably be unable to get free in an emergency and because of the inherent risk of injury if attempts are made to get free.

3.4 Locking the doors

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

3.4.1 Freedom

Freedom to move around and go where one wants to is normal. Any restriction on that freedom by others is a serious matter and should only be considered when an individual is at risk, if out and about unsupervised, and has diminished capacity to judge when and where it is safe to go. Consideration must also be given to any potential risks to others.

3.4.2 Deployment of staff

Theoretically, all locked doors could be avoided by providing sufficient well trained staff for observation and supervision. Realistically this is not possible, but doors, which normally would be open, should not be locked to cover staff deficiencies. Within available resources, deployment of staff should be considered so that one staff member at least has responsibility for supervision of any residents who might be at risk by having an open front door. This staff member should not, however, sit 'on guard'.

3.4.3 Aids to observation

The use of mirrors and alarms (Sections 3.5 and 3.6) should be considered. However, they should never be used simply to make up for deficiencies in observation and supervision by human contact.

3.4.4 Coping with restlessness

Residents who are restless or wandering need proper medical and psychological assessment, treatment where necessary, and a programme of activities which aims to diminish restlessness. Wandering or 'purposeful walking' is not a problem in itself and should not automatically be seen by care staff as such.

3.4.5 Types of locked door

If a door has to be locked there are a number of methods that may be used. Outside doors may have to be locked to outsiders for reasons of safety e.g. to prevent crime, particularly at night, to ensure privacy and to protect residents and staff. However, residents should be assured that all visitors have permission to enter the premises. On the inside of the door there are the possibilities of using double

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handles, code number pads, 'slow door' delayed opening and other special electronic devices, so that staff, visitors and competent residents can use the door. An alarmed open door is a reasonable alternative.

3.4.6 Balance of duty

Staff need to consider the balance between their residents' self-determination and the duty to care, without putting them at unnecessary risk. Doors should be locked only after careful consideration of individual residents' needs, and when alternatives have been fully explored.

3.4.7 Other residents

The position of residents who do not need the door locked must equally be fully considered, so that they can have free access to the outside world. They should have written information and instruction, if necessary, on how to come and go from the care setting.

3.4.8 Sharing information on policy

Policy on door locking needs to be clearly stated at admission and available to staff and visitors. The information should include information on how the resident can come and go freely.

3.4.9 Use of legal provisions

Where a resident is repeatedly attempting to leave through a locked door or otherwise protesting, there should be a full re-assessment of the reasons for his or her restlessness and of the care needs, including the need for any specialist input. Use of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000 should always be considered in such a case.

3.4.10 Personal space

Within a care home individual residents should, where possible, be able to lock their doors for security of their possessions, and lock themselves in their room for privacy. Key access should always be possible for staff to gain access if absolutely necessary. Residents should never be locked in their rooms.

3.4.11 Design

Wards and homes for people with dementia or learning disabilities should be designed in such a way that exits are easily observable by staff at all times, and that exits go to outside areas that are in view, e.g. front doors should be visible from the main sitting area. There should be sufficient space to walk about in. Places where residents walk should not encourage approaches to the exit. They should be spacious and interesting. The long central corridor leading to the front door is an example of poor design. Front doors can be set to one side and de-emphasised. Fire regulations will, of course, have to be taken into account. Wherever possible, front doors should be

reserved for the use of patients and their visitors. All care areas should have a safe outside space in which to walk about, such as an enclosed garden or patio, or a large conservatory which residents should have access to at all reasonable times.

3.4.12 Modifications to design

In wards or homes which are locked, serious consideration should be given to modifying the design to help avoid having to lock the door.

3.5. Wandering technology

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

Increasingly, technology is being used in care homes, hospitals and domestic settings to assist people with impaired capacity, to function as independently as is practicable. Previous editions of this guidance referred to the use of electronic 'tagging' in the care of people with dementia or learning disabilities. The term 'tagging' is often associated with the criminal justice system and with surveillance, shoplifting and the prevention of crime. Global positioning systems are used in conjunction with electronic tags as alternatives to imprisonment or to monitor potentially dangerous offenders. The use of electronic tagging described here is in relation only to care settings and is unrelated to any aspect of the criminal justice system.

The term wandering suggests aimless walking. This may be sometimes the case, but it is more likely that the behaviour has some meaning for the person

concerned. It is important to recognise where the person is trying to go and to recognise that walking to particular destinations of interest will be of benefit to the person. To be prevented from making your way to somewhere you wish to be can be very distressing, particularly in the context of confusion and impaired memory. It is very important to recognise that wandering is not necessarily negative and that the person must be enabled to walk as freely and safely as is possible.

The Commission has produced specific guidance on the use of wandering technologies. 'Safe to Wander' can be downloaded from www.mwscot.org.uk.

3.5.1 Definition

Tagging is an emotive term when used in care settings and we choose to refer to 'wandering technology' as it better reflects the purpose of such equipment. Wandering technology involves the attachment of an electronic device to a person or their clothing, so that if they pass across a particular boundary an alarm goes off, and staff are somehow alerted. Wandering technology can

also involve tracking devices which can locate the wearer if he or she becomes lost or fails to return.

3.5.2 Assessment

As set out in the general principles of this guidance, prior to the use of any form of wandering technology there must be a full physical and psychological assessment to identify the cause of the person's wandering behaviour.

3.5.3 Freedom

Here again, it must be stated that going outside the boundaries of the care home or hospital will not be a problem for many residents. Freedom of movement is the norm and any restriction on that freedom by others is a serious matter. Restriction should only be considered when an individual is at risk if out and about unsupervised and where he or she has diminished capacity, to the extent that his or her judgement about his or her own safety is impaired.

3.5.4 Extent of use

Wandering technology should not be considered unless a particular individual is at serious risk from wandering and where all alternatives have been tried and failed. It is highly unlikely that all, or even a few, residents in one unit would have a device applied, even in an old-age psychiatry-continuing care ward. The use of wandering technology devices must be enabling to the wearer, not limiting.

3.5.5 Freedom of movement

Residents in whose care wandering technology is being applied should, in all cases, have their freedom of movement and choice of activity enhanced by the procedure, not diminished. If this is not the case the technology could be seen as an unwarranted invasion of personal liberty.

3.5.6 Care plan

Wandering technology should never be the only element of a care plan. It should be part of a wider plan which also addresses the resident's need for movement and activity in a positive way.

3.5.7 Visibility

If wandering technology is found to be necessary for certain individuals, they should be discreetly applied, so that the resident is not 'labelled'. Furthermore, to be effective, they need to be small, comfortable and unobtrusive for the benefit of the person themselves. A visible, uncomfortable device is likely to be undignified, stigmatising and rejected.

3.5.8 Individual attention

Wandering technology should not be an excuse to ignore a resident. If attention is only paid to residents when they breach the boundary of the care area, it is almost inevitable that they are getting the wrong kind of attention and missing the attention that they require. Attention at the boundary might even encourage wandering by bringing a reward.

3.5.9 Discretion

Breaching the boundary need not inevitably lead to restrictive action by staff. In many cases it may simply lead to discreet observation, allowing the resident to return of his or her own volition, or to staff engaging the resident in some outside activity, such as going for a walk.

3.5.10 Guidelines

For each individual case, the procedures and responsibilities for responding to the alarm must be clearly worked out and recorded in the care plan.

3.5.11 Temptation to over-use

Wandering technology should not be used just because it is available. It is perfectly acceptable to have a wandering technology system which is not in active use by any resident at a particular time.

3.6 Video surveillance

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

3.6.1 Definition

Video surveillance is sometimes considered to assist observation of common spaces, such as day rooms and corridors, of boundaries such as doors, and, less often, of residents' private spaces.

3.6.2 External security

Video surveillance is sometimes used for external security of care premises, to prevent crime and in this context is perfectly acceptable. It could also be used to help locate residents who have gone beyond the boundary of the care area, for example, in association with a tagging system. This again may be acceptable as long as the general principles of restraint and the considerations below are applied.

3.6.3 Monitors

Video surveillance could only be effective if a member of staff attends a monitor at all times of risk. In most cases this is likely to be undesirable. The staff member would be better employed in direct contact with residents. Monitors placed in staff rooms, nursing stations or reception desks will inevitably compete for the attention of staff involved in their normal duties and activities.

3.6.4 Court ruling

In a fatal accident inquiry at Airdrie Sheriff Court in 1991 the Sheriff suggested that video surveillance in unmanned corridor areas could increase safety and was acceptable, if it did not impinge on the privacy of individuals. However, the Commission is of the view that the privacy of individual residents is paramount and video surveillance should not be used in private living areas such as bedrooms, bathrooms or toilets.

Care of people with a mental disorder is best carried out through human interaction.

3.6.5 Design and staffing

A care unit which has significant public areas, such as corridors or reception areas, which are not easily visible to care staff should consider whether alterations to design are possible and should review staffing levels.

3.6.6 Accidents

Video surveillance and passive alarms are unlikely to prevent individual accidents, since most of these happen very quickly, though it could be argued that immediate awareness of an accident can bring help sooner.

3.6.7 General effects

Unlike other methods of restraint, video surveillance is indiscriminate. It is most unlikely that more than a few residents in any care unit would require such observation. The potential intrusion into the privacy and freedom of other residents needs to be carefully considered when video surveillance is contemplated. The consent of all residents involved should be sought wherever possible.

3.6.8 Temptation to over-use

If surveillance is available it is likely that there will be a temptation to rely on it excessively and see it as 'labour-saving'. This is undesirable. Care of people with a mental disorder or learning disabilities is best carried out through human interaction.

3.6.9 Individual surveillance

Video or microphone surveillance in a person's private living space is unlikely to be justified, given the considerations above. However, there may be unusual circumstances where, if possible with the person's consent, such surveillance can be seen as enhancing the person's freedom of movement and choice. While this may be considered as part of a wider care programme, the problem of monitoring, the absence of personal contact and the intensive nature of the surveillance all argue against its use.

3.7 Passive alarms

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

3.7.1 Definition

'Passive alarms', including pads under mats beside the residents' beds or at bathroom or external doors, and infra-red alarms, are being increasingly used in care homes. Infra-red alarms can be programmed to be alert to a person's specific habitual actions. A passive alarm, signaling a particular resident's movements, is a less restrictive option than video surveillance and may be more easily justified, as long as the general principles on restraint are followed.

3.7.2 Monitoring the alarm

'Passive alarms', are only effective if staff are available to attend when the alarm sounds. Alarms should be discreet and should cause the minimum possible interference to other residents.

3.7.3 Accidents

Passive alarms are unlikely to prevent individual accidents, since most of these happen very quickly, but immediate awareness of an accident can bring help sooner.

3.7.4 Information to the individual

In all cases where passive alarms are used as part of a care plan, the resident and relevant others including relatives, advocates, welfare attorneys/guardians or other representatives, should be informed as fully as possible of their existence and the consequences of crossing the boundary. There should never be any sense of threat in this information.

3.8 Medication as restraint

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

3.8.1 Definition

This is the use of sedative or tranquillizing drugs for purely symptomatic treatment of restlessness or other disturbed behaviour. Drug treatments for medical or psychiatric conditions which underlie the disturbance are not included. For example, an antidepressant may be used to treat a person who is suffering from depressive illness, one of the symptoms of which is agitation. It must be recognised, however, that the boundary between these two methods of drug use is not always clear. For example, it is sometimes postulated as a justification for tranquillizer use that restlessness is due to an underlying, but unidentified, distress.

3.8.2 Assessment

A full and clear multi-disciplinary assessment of the symptoms of disturbance and their causes is essential before drug treatment of disturbed behaviour is considered. Any drug

treatment used should be for a specific purpose after such full assessment.

3.8.3 Alternatives

In most cases drug treatment can be avoided unless there is a clear underlying cause, such as a medical condition, depression, fixed delusions, severe anxiety or emotional lability.

3.8.4 Monitoring

Whenever a drug treatment is used, frequent medical monitoring of the dosage and its continuing need must be carried out for as long as the drug is prescribed. It is essential, therefore, that the resident, and as far as possible, informal and formal carers, know the reason for the prescription and the signs of its success.

3.8.5 Side-effects

It is vital that all concerned are fully aware of potential side-effects. Most tranquillizer and sedative drugs have a range of side-effects which need to be carefully monitored. These side-effects may include restlessness, which can lead staff to feel mistakenly that an increase in drug dosage is required.

3.8.6 Medical responsibility

For all these reasons, the prescribing doctor should be closely and continually involved with any resident who has been given sedative or tranquillizer drugs over a period. Staff need to have easy access to a doctor on call.

3.8.7 Individual variation

There are enormous variations in individual responses to drugs and in some cases a process of 'trial and error' will have to be used. Again, the role of the doctor is central to this.

3.8.8 Consent

There are many circumstances when a person will consent to drug treatment for distressing restlessness. In other cases the person may be incapable of giving consent, but is not obviously objecting to the treatment. Welfare attorneys and welfare guardians appointed under the Adults with Incapacity (Scotland) Act 2000, if granted the power, may give consent to certain treatments. Part 5 of the Adults with Incapacity (Scotland) Act 2000 makes provision for the medical treatment of adults with

impaired capacity. Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision for the treatment of mental disorder. In cases where a person with a mental disorder is incapable or refuses to consent to tranquillizing or sedative drug treatment, and the treatment is considered necessary, the use of the 2003 or 2000 Acts must be considered.

3.8.9 'Disguised' or covert medication

The giving of medication, for whatever reason, without the consent or knowledge of a resident or patient is potentially an assault and should only be considered in exceptional cases. The Mental Welfare Commission is producing separate guidance on the covert use of medication.

3.8.10 Intermittent disturbance

Much disturbed behaviour is intermittent rather than constant. It is not generally good practice to give a long-acting depot drug for disturbed behaviour which happens only occasionally. It is preferable that staff learn how to anticipate

episodes of disturbed behaviour and defuse the situation, or divert the person into other activities.

3.8.11 Control of drugs

Tranquillizing and sedative drugs are potentially poisonous and open to abuse by patients and others. It is vital that all care settings have a system of individual prescription and recording of administration and stock control under the supervision of managers, pharmacists, doctors and inspection teams, in accordance with the relevant legislation and guidance.

3.9 Indirect limits to freedom

This guidance should be used only in conjunction with the general principles of Section 1 of this paper.

3.9.1 Restraint by default

Examples of restraint by default include the resident's movement being limited by deliberately not being provided with walking aids or a wheelchair, not being assisted with stairs or where there is no lift. These indirect actions must be recognised as restraint and be subject to a full process of assessment and review. Such interventions are highly undesirable and should only be considered in the context of the resident's wider care and then only when it is clearly in the interests of the resident.

3.9.2 Restraint as a result of interpersonal control by staff

For example, verbal control by staff such as distracting someone who is trying to leave the home or being 'guided' without physical contact, can be considered restraint when they are regularly used as a method of controlling the resident's desired actions. These

interventions may be the least restrictive intervention and may be preferable to more restrictive methods of controlling behaviour. However, where such interventions are regularly used then they should be considered as a form of restraint and be fully assessed and discussed as part of that resident's plan of care.

People using restraint need to ensure that what they are doing complies with the law.

Appendix 1: A discussion of the legal issues relating to restraint

i. Introduction

People using restraint need to ensure that what they are doing complies with the law. The law says that it is wrong to interfere with the actions of another adult without lawful excuse. This means that restraint is potentially a legal wrong unless legally authorised. This section looks at when the use of restraint can be lawful and the requirements the law imposes.

Neither the civil nor the criminal law in Scotland is set out in a precise code. There is no specific piece of legislation dealing with 'restraint', setting out what is lawful in a hospital or care setting and what is not.

The law relating to the use of restraint is largely the common law. This is law which has developed over the years as cases come before the courts. Certain powers to restrain may be available under the Adults with Incapacity (Scotland) Act 2000 and implied under the Mental Health (Care and Treatment) (Scotland) Act

2003. There are also regulations under the Regulation of Care (Scotland) Act 2001 concerning the use of restraint by care providers.

The European Convention on Human Rights has had a major impact. The law must now be read in light of human rights requirements. This means that it should be accessible and transparent. A public authority, such as a hospital, or any body which receives much of its funding from the public sector, must act in accordance with human rights.

The term 'restraint' encompasses a range of actions intended to limit the ability of a person to do something which another person or persons (in this context either residential care or hospital staff) consider undesirable.

ii. Criminal law

Restraint exercised without legal authority may be a criminal offence. A breach of the criminal law is particularly serious. The responsibility for such a breach would usually lie with an individual, rather than the care home or hospital employing him or her. A staff member convicted of breaking the criminal law by an act of restraint could be liable to a fine or even imprisonment (as well, of course, as disciplinary action). The standard of proof required to obtain a criminal conviction is high (*'beyond reasonable doubt'*).

The process of establishing a criminal intention is extremely complex, but it essentially means proving that the person knowingly did something wrong (or was reckless as to whether what he or she did was wrong). Prosecution is the responsibility of the Crown, exercised through the local procurator fiscal. There will not normally be a prosecution unless the evidence is sufficiently strong to make a conviction reasonably likely, *and* it is in the public interest for the case to go to trial.

Criminal cases involving restraint have been rare in Scotland. There would not normally be a criminal prosecution, unless the restraint goes beyond what most care professionals would accept as justified and is tantamount to abuse.

Improper use of restraint could constitute a crime under a number of legal provisions:

Assault

Assault is a 'common law' crime. This means that it is not defined in any Act of Parliament. Instead a judge or sheriff decides whether particular actions in a particular case constitute an assault. Any physical act which causes injury, affront or harm to the victim could constitute an assault if there is no lawful justification for its use. Actions such as holding down a person, tying the person down, or threatening or intimidating gestures could be assaults. Assault committed by a person in a caring role is particularly serious and might be prosecuted as 'aggravated assault'.

Unlawful detention

It is a crime to detain a person against his or her will without legal authority. Clearly some forms of restraint could constitute 'detention'. Detention generally requires legal authority. See below. There is a common law power to detain persons of unsound mind who are a risk to themselves or others until a 'warrant is obtained', but this is not available to people or agencies who have statutory powers to detain people available to them¹.

A doctor or hospital should normally use the provisions of the Mental Health (Care and Treatment) Act or the Adults with Incapacity Act if someone needs to be detained in a hospital or community setting. Other people or agencies who may lack statutory powers of detention should detain only for as long as may be reasonably necessary to allow the proper authorities to intervene.

Cruel and unnatural treatment

This common law crime encompasses a range of activities, such as refusing to feed a person, or acting in a way incompatible with his or her human dignity. The treatment would have to be something generally agreed to be outside the accepted norms of caring for vulnerable adults.

Adults with Incapacity (Scotland) Act 2000

Section 83 of this Act makes it an offence for anyone exercising powers under the Act to ill-treat or wilfully neglect a person with mental incapacities in his or her care.

Mental Health (Care and Treatment) Act 2003

It is an offence for anyone employed in, or providing services to, a hospital or providing care services to ill-treat, or wilfully neglect anyone under his or her care. This is regardless of whether the person is subject to an order under the Act.

¹ *B v Forsey* 1988 SLT 572(HL).

iii. Civil law

Illegal or inappropriate restraint may be a civil wrong. Someone who has been wrongfully restrained can seek damages, and/or a court order preventing any future unlawful restraint. Any action which could constitute criminal offence would almost certainly also be a civil wrong. It might be possible to take civil action even where a procurator fiscal has decided not to prosecute.

It is not necessary to prove any malicious intention to establish a civil wrong. Breach of a duty of care can amount to a civil wrong. Furthermore, it is easier to prove a civil case, in that a wider range of evidence is admissible, and the standard of proof is lower (the '*balance of probabilities*' and not the criminal test, which is 'beyond reasonable doubt').

A civil action depends on the person who has allegedly been harmed (or his or her legal representative) taking the matter to court. The person would normally take legal action against the employer, not the staff member alone, unless the employee has acted in a way that was inconsistent with his or her contract of employment.

Even where restraint is justified, there could be a civil case if the restraint caused harm unnecessarily or took place for too long. If it is foreseeable that restraint may be necessary, the law would expect that there would be a risk assessment, the restraint should form part of the person's care plan, and that staff will have received proper training.

Some of the classes of civil wrong which might be relevant include:

Assault

The definitions and possible defences are broadly similar to those discussed for the crime of assault.

Unlawful detention/wrongful apprehension/wrongful imprisonment

Where someone is forcibly detained or has a reasonable fear of being seized.

Force and fear

Where someone is intimidated into not doing something he or she is entitled to do, or into doing something he or she would not otherwise do.

iv. Legal justifications for restraint

Even if restraint is justified, it must not be for longer, or involve more force than is reasonably necessary.

Self defence

The common law recognises that someone may use force or restraint if there is reason to believe another person is about to cause him or her harm.

No more than the minimum necessary force can be used. If the person acts in bad faith or uses more force than is reasonably necessary, his or her action is outside the law.

Necessity

The common law also allows someone to restrain another person if this is necessary to prevent immediate harm to others or serious damage to property, or to stop someone from committing a crime.

This could include stopping someone harming him or herself. The level of restraint must be reasonable, and the restraint should continue only for as long as is necessary to bring the situation under control. (Any further restraint to punish the

person is not justified.) What is a reasonable or unreasonable length of time depends on the particular circumstances of each case.

In a Scottish case before the House of Lords, the court said the use of such powers in hospital should only be where someone *'is a manifest danger either to himself or to others'*. The use of restraint by a private individual should be *'temporary'* until the person can be *'handed over to the proper authority'*. A doctor or nurse should use the Mental Health (Care and Treatment) Act rather than common law powers if the restraint amounts to detention². (See part 6 for detention.)

Duty of care

If a learning disability, mental illness or personality disorder puts someone at risk, carers may have a legal duty to restrain the person in his or her own interests. Where someone takes on a caring role, he or she owes a 'duty of care' to the person. This means that the carer must do what is reasonable to protect the person from reasonably foreseeable harm.

If someone's actions could put other vulnerable people at risk, staff have a duty of care to restrain the person to protect other people. The hospital managers have health and safety duties to ensure the protection of their staff. As public authorities, they have human rights duties to protect other patients against abuse.

The courts in Scotland have accepted that nurses have a duty to use reasonable force to 'control' a patient with a mental disorder, for the person's protection or to protect other patients. The force they use should be the minimum necessary and should not go beyond what is normal or permissible good practice³.

Consent

A person may consent to restraint because he or she understands that he or she is at risk. The consent is valid only if the person is mentally competent to take the decision. It is not valid if the person is put under undue pressure to consent or if the restraint is excessive, cruel, unnatural or unnecessary in the circumstances.

In some cases consent may be *implied*. It may be possible to rely on implied consent if the person has the legal capacity to object, is free to leave and accepts the restraint. Any undue pressure would remove the presumption of implied consent.

A person concerned about the use of restraint might wish to make an advance statement or personal statement giving information about how best to treat or respond to certain behaviour symptoms. This might help avoid the need for restraint in the future.

No one can consent to the use of restraint on behalf of another person, unless he or she has specific powers to take such a decision under the Adults with Incapacity Act. (See below.)

² *B v Forsey* 1988 SLT 572(HL).

³ *Skinner v Robertson* 1980 SLT (Sh Ct) 43. *Norman v Smith* 1983 SCCR 100.

v. Safeguards

Restraint must be justified

Any person using restraint has to be able to justify it in a court of law, if necessary. On the face of it, restraint is illegal. It is for the person using it to justify both the use of restraint and the way in which he or she used it. This is a requirement of the common law and the European Convention on Human Rights.

If restraint is excessive, unnecessary, degrading or unnatural, the courts are likely to regard it as an assault as well as a breach of human rights. Those involved could face criminal prosecution.

Care standards

Registered establishments, such as residential care homes and nursing homes, must comply with the reasonable requirements of the Care Commission and any relevant care standards, insofar as they are within the scope of the registration legislation.

The managers of care services owe a duty of care to residents or patients to ensure that staff operate any restraint properly. This involves having a policy about the use of restraint and the recording of incidents, spelling out in the person's care plan how restraint might be appropriate and ensuring that staff called upon to restrain someone have proper training and qualifications.

Regulations made under the Regulation of Care (Scotland) Act 2001 deal with care providers' use of restraint⁴. These regulations apply to care home and day care services, but not NHS hospitals. The regulations stress the importance of treating clients with dignity and respect⁵.

No client is to be restrained other than in exceptional circumstances. Staff should use restraint only if this is the only practicable means of securing the welfare of the client or of other clients.

Staff must record the use of restraint in the client's personal file. The person providing the care service must keep a record of each occasion on which restraint/control is used, giving details of the form of restraint/control, the reason it was necessary and the name of the person authorising it⁶.

The National Care Standards similarly state that staff will explain, justify and record any limits on the person's independence in his or her care plan and will review the plan regularly⁷. Restraint should be a last resort (unless it is legally required).

Standards in NHS

Standards in the NHS are matters of 'clinical governance', the responsibility of the health board and hospital management. All hospitals and community health facilities in Scotland should have policies on the use of restraint, covering its use, training of staff, reporting etc⁸. NICE guidelines in England and Wales give detailed good practice guidance⁹. There does not appear to be anything similar for Scotland¹⁰.

Professional standards and guidance

Most people working in care homes and hospitals are subject to professional standards. Professional standards may cover the use of restraint. All professionals will need to ensure that they can justify any decision to use restraint in the light of their professional and ethical standards.

Contractual obligations

Any establishment providing services under contract to a local authority must comply with the terms of the contract. The local authority might impose requirements about proper policies on restraint, reporting, recording etc. Similarly, if a local authority chief social work officer delegates certain of his or her guardianship powers to a care home, he or she should monitor how these powers are exercised and should be clear that the establishment's rules on issues such as restraint are appropriate.

Health and safety issues

Employers have a legal responsibility to take reasonable steps to secure the health and safety of their workforce, and are obliged to undertake risk assessments of potential hazards. Employers must anticipate situations where clients may cause risks to staff, and devise appropriate methods to minimise these. These duties reinforce the requirement for employers to train staff in safe methods of restraint where necessary.

Limits to common law

If someone is likely to need restraint on a regular basis as part of a care package, those involved should consider the use of a guardianship order under the Adults with Incapacity Act or a compulsory order under the Mental Health (Care and Treatment) Act. The person should have the rights of appeal to the courts or the Mental Health Tribunal and recourse to and supervision by the Mental Welfare Commission available under those Acts.

The Scottish Law Commission recommended someone exercising extensive informal controls over someone's life on a regular basis should seek an Adults with Incapacity Act order¹¹. Regular use of restraint is exercising extensive controls. If restraint could amount to a deprivation of liberty within human rights law, an order is essential. See below.

Reporting of incidents

Any injury caused during the use of restraint should be the subject of critical incident reviews locally and be reported to the Mental Welfare Commission. The Mental Welfare Commission has established a protocol with the Care Commission for reporting incidents.

⁴ The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, SSI 2002/114.

⁵ SSI 2002/114, reg 4.

⁶ Regulation 19(3).

⁷ National Care Standards care homes for people with mental health problems Scottish Executive December 2001 (revised March 2005), care standards 6.2, 17.

⁸ NHS Scotland *Managing health at work partnership network guidelines*, Scottish Executive 2004, guideline 6.

⁹ National Institute for Clinical Excellence, *The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments* February 2005.

¹⁰ The latest information from the Scottish Executive is in *Safe care: consideration of the recommendations from the inquiry (England) into the death of David Bennett* Scottish Executive Health Department 17 December 2004.

¹¹ *Report on incapable adults*, para 2.53.

vi. Human rights safeguards

Human rights law is likely to become increasingly important in considering matters such as the appropriate use of restraint. This is a matter for the Scottish courts as well as the Court of Human Rights in Strasbourg.

Article 3 of the European Convention on Human Rights prohibits inhumane and degrading treatment. Poor practice on restraint could fall within this category. If treatment is inhumane and degrading, it is not a defence that it is necessary for the person's protection.

The use of restraint could also be challenged under Article 8, respect for private life. Article 8 permits interference with someone's autonomy if this is lawful and necessary for public safety, the protection of health or the protection of others. Any of these might be a justification for the use of restraint. Staff should tell the person why he or she is being restrained, if possible.

A lesser known article of the European Convention on Human Rights gives a right

to liberty of movement within a country's boundaries¹². Restraint could constitute a breach of this right. A person's freedom of movement may be restricted if this in accordance with the law and necessary for the protection of public safety, the prevention of crime, or for the protection of rights and freedoms of others. Restraint would generally be justified on one of those grounds.

Articles 8 and protocol 4 allow interference with human rights, provided the interference is lawful. The common law can satisfy this requirement, but it must be consistent, clear and accessible¹³. Clear policies can help to provide such clarity and consistency. If a public authority has no such policy, this could be open to challenge on human rights grounds¹⁴.

A very important human rights requirement is that any restriction of someone's liberty should be in proportion to the risk posed. Even if the use of restraint is justified, it will become unlawful if the methods used are excessive or if it continues for longer than necessary.

Restraint and detention

Article 5 gives the right to the liberty and security of the person. There is an exception for people of 'unsound mind', who may be detained in the interests of their health and safety or that of others.

There must be objective medical evidence that the person is of 'unsound mind'. The person's condition must justify compulsory detention and the condition must persist throughout the detention¹⁵. The detention must be in accordance with a procedure prescribed by law. (Less stringent requirements apply in emergencies, although a doctor should see the patient as soon as possible.)

If restraint could constitute 'detention', those involved should seek legal authority for the detention, under either the Mental Health (Care and Treatment) Act or through under the Adults with Incapacity Act. Reliance on common law powers is unlikely to satisfy the ECHR requirements of due process. The difference between restraint and detention is a matter of degree. There is no

difference in the nature or substance of the controls. The law says restraint is a restriction on someone's liberty and detention is deprivation of liberty. Regular and consistent restraint may amount to detention.

Whether someone has been deprived of his or her liberty depends on the specific situation of the individual concerned. The court takes account of a range of factors such as:

- The degree and intensity of the controls over the person's movements.
- For how long these controls are likely to be necessary.
- The intentions of those controlling the person. If the intention is to stop him or her from leaving, there may be a deprivation of liberty even if the person does not attempt to leave or staff persuade him or her not to leave.
- How the controls are used. Physical restraints can amount to detention, as can the use of sedation and observation.

- What access to the outside world the person is likely to have, including access to family and carers.
- Whether the person is likely to attempt to leave. If someone attempts to leave and staff stop him or her, this is likely to be a deprivation of liberty. It is more complex if the person does not attempt to leave or makes an 'uninformed' attempt to leave, perhaps of not understanding where he or she is or where the door leads.
- Whether the cumulative effect of restrictions could amount to detention¹⁶.

Legal advice may be necessary as to whether arrangements amount to detention. Guidance from the Scottish Executive is expected shortly.

Arrangements which involve restraint to a certain degree, yet aim to give someone the maximum freedom consistent with any limitations because of the person's disability, may not constitute a deprivation of liberty but may be seen as respecting the person's right to life and health. The courts

in England have said that restrictions primarily for the benefit of the person, as opposed to protecting the public, might not be deprivations of liberty¹⁷.

In conclusion, to ensure that the use of restraint complies with human rights law:

- Restrictions on a person's liberty should be necessary in the circumstances.
- If a person is shown to have a genuine mental disorder, the European Convention on Human Rights recognises that he or she may need restraining either in his or her own interests or to protect others.
- Any restrictions should be reasonable and should last only as long as necessary.
- If there is a complaint, the court will investigate whether the use of restraint was both in accordance with good practice and appropriate in that particular case.
- The person should have the reasons for the restraint explained to him or her.

- If the use of restraint could amount to detention, legal authority will be necessary under either the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act.

Those exercising restraint, therefore, will have to be prepared to justify their policies and their use of such policies in individual circumstances. They will need to obtain specific legal authority for any restraint tantamount to detention. In all other cases if the use of restraint is in accordance with generally agreed good practice, it is unlikely that there would be a breach of the European Convention on Human Rights.

- ¹² The European Convention on Human Rights, Fourth protocol, Article 2.
- ¹³ See *HL v UK* (2004) ECtHR 471 at para 116. (The 'Bournewood' case.)
- ¹⁴ *R v. Ashworth Hospital Authority ex parte Munjaz* (2005) UKHL 58.
- ¹⁵ *Winterwerp v the Netherlands* (1981) ECHR 7.

¹⁶ *HL v UK* (2004) ECtHR 471 at para 89.

¹⁷ *R (Secretary of State for the Home Department) v Mental Health Review Tribunal* (2002) EWCA Civ 1868; *R (G) v Mental Health Review Tribunal* (2004) EWHC 2193.

vii. Restraint and the Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity Act provides a comprehensive framework for taking medical, welfare and financial decisions for people who are unable, because of mental disorder, to take such decisions themselves.

‘Incapacity’ means someone is not able to make decisions or take actions about the particular matter in question. A person may be incapable because he or she cannot act, make a decision, understand the decision, communicate or retain the memory of the decision. The test relates to the decision which has to be taken. Someone may be able to decide, for example, what he or she wants to wear, but if the person is not able to act to protect his or her own welfare, he or she would fall within the ambit of the Adults with Incapacity Act for this purpose.

The Adults with Incapacity Act does not do away with the existing law, such as on duty of care, self-defence, necessity etc. The Act does not deal specifically with restraint, but if someone is unable to take decisions on such matters him or herself and there is a need to get legal authority to restrain him or her, the Act may allow those involved to apply for an order authorising restraint.

There have been some calls for the Scottish Executive to make regulations under the Adults with Incapacity Act to cover the use of restraint in Scottish care homes and hospitals. The principles on the use of restraint would still apply in such circumstances, as would the Adults with Incapacity Act principles.

Adults with Incapacity Act Principles

The Adults with Incapacity Act sets out the general principles which should apply before there is any intervention under the Act. These principles represent agreed good practice. They could usefully form part of any restraint policy. Any court hearing an application under the Adults with Incapacity Act will consider the application of the principles. A guardian or attorney appointed under the Act must comply with the principles.

These principles, which are set out in Part One of this Guidance, are very important. People acting under the Adults with Incapacity Act have legal protection from liability if they act in accordance with them. If they do not, that protection fails¹⁸.

Medical treatment

If someone is incapable of taking medical decisions, the doctor or health professional treating him or her will have a general authority under Part 5 of the Adults with Incapacity Act to do what is reasonable to promote or safeguard the person's mental or physical health if he or she signs the necessary certificate of incapacity.

The health professional cannot use force or detention unless this is immediately necessary and only for so long as necessary¹⁹. If ongoing restraint or detention is appropriate, he or she should consider seeking an order under Part 6 of the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act²⁰. An example would be where someone in community facilities needs restraint in connection with the giving of care such as washing or dressing. An Adults with Incapacity Act order might be appropriate. An order under the Mental Health (Care and Treatment) Act would not be appropriate, as the treatment is not for 'mental disorder'.

A health professional can give medical treatment to someone unable to consent to treatment even if the person objects to or resists the treatment. If the person is likely to object on an ongoing basis, the health professional should consider an order under the Adults with Incapacity Act or Mental Health (Care and Treatment) Act.

Restraint and guardians

The Adults with Incapacity Act is not clear how far it is appropriate for a welfare guardian to use force, restraint and/or detention if an adult does not comply with the guardian's instructions. This contrasts with the Mental Capacity Act for England and Wales, which clearly limits the circumstances in which a guardian (called a 'deputy') can use force or restraint²¹.

The Part 6 Code of Practice does not envisage the use of force or detention by guardians. It says that on occasions a guardian may have to 'insist' on having his or her way, but it links the use of compulsion to the enforcement procedures in the Act²². Alternatively,

it suggests, a guardian may wish to seek directions from the sheriff.

It may be that the law should draw a distinction between local authority guardians and personal guardians for these purposes. A personal guardian who is a carer may be able to rely on common law powers and duties to restrain the person. The law is less happy with statutory bodies relying on common law powers, particularly when a statutory code is available²³.

Applying for power to restrain

It would be good practice for any prospective guardian envisaging the use of restraint, force or detention to refer to this specifically in the guardianship application. Such significant limitations on the adult's civil liberties should be explicit, not implied in a general grant of powers to take all welfare decisions for the person.

Where the chief officer of the local authority is guardian, he or she will want to ensure that the restraint policy in the place where the person is to live is acceptable and properly monitored. The guardian

remains liable for the proper performance of his or her functions. He or she could be liable of criminal neglect if people acting on his or her behalf are negligent or poorly trained.

Attorneys

The Act does not give welfare attorneys any power to exercise force or restraint. The power of attorney document could specifically authorise the attorney to exercise such restraint as the person might need, in accordance with the principles of the Act. If the document does not give such powers, the attorney who is a carer will need to rely on his or her common law powers and duties (see above). If a power of attorney contains the power to approve where the person should live, this could include the power to decide he or she should live in a place which may restrict his or her liberty, if appropriate under the principles of the Act.

¹⁸ Adults with Incapacity (Scotland) Act 2000, s82.

¹⁹ Adults with Incapacity (Scotland) Act 2000, s47(7).

²⁰ The Part 5 Code of Practice mentions the possibility of Mental Health (Care and Treatment) Act orders, but not guardianship orders in this situation (para 2.55). A local authority has duties to apply for an order if needed to protect the person's interests. Adults with Incapacity (Scotland) Act 2000, s57(2).

²¹ Mental Incapacity Act 2005, s20.

²² Paras 5.49, 5.70-71, 5.85-86.

²³ *B v Forsey* (above) and *HL v UK* (above).

viii. Restraint and the Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 authorises the use of compulsory measures, where a person's mental disorder makes him or her a risk to others and the person's ability to take treatment decisions is significantly impaired. A person may be detained in hospital or required to live in a specified place in the community. The person may be required to accept medical treatment even if he or she does not consent to the treatment.

There is very little in the Act or its Code of Practice dealing with the use of force and restraint but the law says that the statutory powers in an Act of Parliament include any related powers necessary to operate the powers in the statute²⁴.

If a patient challenges the use of restraint, the hospital will need to be able to demonstrate that it has the legal authority to act and that its action is an appropriate response in the individual circumstances of the case.

It will also need to show the use of force is in accordance with the principles of the Act, and in particular is the least restrictive alternative.

Restraint in hospital

Although the Act does not state this explicitly, the fact that someone is detained in hospital means that staff have authority to restrain the person if he or she attempts to leave the ward or the hospital or without the consent of the responsible medical officer. The person cannot leave the hospital without the authority of the responsible medical officer²⁵.

A person subject to compulsory measures under the Mental Health (Care and Treatment) Act will generally be subject to an order requiring him or her to accept medical treatment under Part 16 of the Act. Medical treatment is widely defined. It includes nursing and care²⁶. Nursing could include restraining someone to prevent risk to self or others, if necessary and in accordance with the principles of the Act.

The Act authorises the giving of medical treatment where the person does not consent. The Act does not say that staff may use force or restraint to give such treatment if the person resists, but this is a necessary consequence. The Act does not authorise force to treat a person while he or she is in the community²⁷. The implication is that someone in hospital can receive treatment by force in certain circumstances.

The Code of Practice deals with the use of force, but only in the context of urgent treatment. If staff use force to give urgent treatment, they should have received training in its use and should include details about any use of force in their report to the Mental Welfare Commission²⁸.

Restraint in community-based settings

Staff supervising someone living on a community-based compulsory treatment order should not use force or restraint to keep the person there, if the person attempts to leave. A community-based compulsory treatment order does not detain the person in the community facility, but

requires him or her to live in the place specified in the order. If the person leaves, he or she is in breach of the order. The person may be brought back to the place where he or she is to live, or taken to hospital. This does not mean that there is a power to detain or restrain the person in the community. People living in the community cannot receive medical treatment by force. (See above.) This means that they cannot receive nursing care such as restraint.

If a hospital-based order is suspended and the person is kept in the charge of a nurse or other person, it would seem likely that the Act would allow the nurse to restrain the person should he or she attempt to leave. The person remains a detained patient, subject to the control of the responsible medical officer, even though the order is suspended.

Safeguards

The fact that a person is subject to compulsory measures under the Mental Health (Care and Treatment) Act does not remove the need for monitoring and recording of the use of restraint. All the safeguards above apply.

The principles of the Act, and in particular the principle of minimum necessary intervention, mean that any restraint should be justifiable in the circumstances and the minimum necessary to deal with the situation. A nurse or other professional unable to show he or she has acted in accordance with good practice and with reference to the principles of the Act might have difficulty in justifying his or her action to a court.

Code of Practice

There is little in the extensive Mental Health (Care and Treatment) Act Code of Practice about the use of force or restraint. The Code of Practice recommends that staff advise informal patients of their rights when they are admitted to hospital. This should include information about any restrictions on movement staff may

prescribe. The Code concludes that inappropriate use of restraint or limitations to an informal patient's liberty might constitute ill-treatment or wilful neglect²⁹. A person whose liberty is restricted in this way could appeal to the Tribunal under section 291 of the Act. The Tribunal could decide that, although the patient is an informal patient, he or she is unlawfully detained.

²⁴ Bennion, *Statutory Interpretation*, 4th edition, section 174.

²⁵ See, for example, Mental Health (Care and Treatment) (Scotland) Act 2003, s127. Only the responsible medical officer can suspend the terms of a compulsory treatment order to allow the person to leave.

²⁶ Mental Health (Care and Treatment) (Scotland) Act 2003, s329.

²⁷ See, for example, s241(4).

²⁸ Code of Practice, vol 1, para 10.87.

²⁹ Code of Practice, vol 1, paras 8.05-07.

ix. Restraint of children and young people

Different rules apply if a child or young person requires restraint.

Generally the child's parent(s) (or the people with parental responsibilities and rights in respect of the child), have the right and the duty to take what action is necessary to protect a child or young person until he or she is 16. This could, on occasions, include the need for restraint. A person with temporary care of the child or young person also has such powers and duties. These powers must be exercised reasonably and in the interests of the welfare of the child.

The kind of restraint that is appropriate for a three-year-old would not be appropriate for a 15-year-old. Parental rights must be exercised in good faith. Restraint that is cruel, humiliating or manifestly unnecessary would not be lawful.

If medication is intended at least partly to restrain a child or young person, the parent can consent to this on the child's behalf until the child has sufficient maturity and understanding to make a competent decision him or herself.

If a child or young person with capacity to make medical decisions refuses such treatment, a health professional must respect the refusal. He or she may consider using other means, such as compulsory measures under the Mental Health (Care and Treatment) Act or applying to the court under the Children (Scotland) Act 1995.

x. Medical treatment and restraint

A person may require medication for the purpose, at least in part, of restraining him or her. Medical treatment requires the consent of the patient, unless the treatment is authorised under the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act.

There is a common law power to give a person medical treatment without his or her consent in an emergency. This could include giving medication where the purpose is at least in part to restrain a person, if this is immediately necessary for the protection of the person or others. Long-term use of such powers would not be permitted under the common law. Appropriate authority should be sought under the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act as appropriate.

Covert medication

Covert or disguised medication describes the practice of concealing medication in food or drinks. The patient does not know he or she is receiving the medication. The Mental Welfare Commission gives guidance on page 21 of this guide.

A patient with legal capacity must never receive medication surreptitiously. This would be an assault, a civil wrong. Where someone is unable to consent to treatment, and is likely to resist or object to the treatment, it may be appropriate for a doctor or healthcare professional to give medication surreptitiously in exceptional circumstances.

Guidance from the British Medical Association recognises that it may sometimes be appropriate to give medicines covertly where this is authorised by law, and as an alternative to giving the treatment by force³⁰. There is also guidance from the Royal College of Psychiatrists³¹ and the Nursing and Midwifery Council³². The National Care Standards say that even if the law

allows treatment without the person's consent, the person should receive covert medication only if he or she has refused treatment and his/her health is at risk. Any use of covert medication should be recorded³³. Any decision to give covert medication requires the authorisation of the doctor who prescribed the treatment. This is a requirement of the Medicines Act³⁴.

All sources of guidance stress that there must be a clear medical need for the treatment and that the measures will avoid significant mental or physical harm to the person. The decision to give covert medication should be discussed within the team and with carers and significant others and recorded.

Medication should not be given surreptitiously for the convenience of staff.

The Royal College of Psychiatrists says such treatment can be justified only when there is no likelihood that the person will be able to take treatment decisions. It is not suitable for someone with a mental illness such as schizophrenia.

Giving medicines in a different form may alter its effects and may mean that the use of the medication is unlicensed³⁵.

The doctor should seek advice from a pharmacist before approving the covert administration of medication. Staff should make regular efforts to persuade the person to accept the medication and staff should regularly review a decision to give covert medication.

Any staff member who fails to have regard to such guidance could face a charge of professional misconduct as well as criminal charges, if medication is given covertly to someone who has capacity to refuse the treatment.

The Mental Welfare Commission is currently drafting more detailed guidance on covert medication.

³⁰ *Medical ethics today* BMA 2004.

³¹ College Statement on Covert Administration of Medicines *Psychiatric Bulletin* (2004) 28: 385-386.

³² *Position statement on the covert administration of medicines* August 2005.

³³ National care standards, care homes for people with mental health problems, March 2005, standard 15.13.

³⁴ Medicines Act 1968, s58(2)(b).

³⁵ *Tablet crushing and the law* Richard Griffith, the *Pharmaceutical Journal* (Vol 271) 19 July 2003.

xi. Summary

Although the law is complex and restraint covers a variety of activities, the following is a general summary of the law.

- Restraint is unlawful unless there is a legal justification. The most common justification is the prevention of harm to others or to the person being restrained.
- The degree and type of restraint should always be the minimum which is reasonably necessary, for the minimum possible time.
- Caregivers should anticipate when restraint might be required, plan accordingly and train staff.
- Establishments should have policies on the use of restraint available to clients, their relatives and carers, registration authorities and commissioners of services. All policies should comply with relevant care standards as appropriate.
- Where restraint constitutes 'detention', legal authority for such use must be obtained. A doctor or local authority may seek authority under the Adults with Incapacity (Scotland) Act 2000 or may need to seek a compulsory order under the Mental Health (Care and Treatment) (Scotland) Act 2003.
- Restraint must be for a clear purpose and if possible the client should be told what this purpose is.
- Restraint should not be used as a punishment, or done with hostile intent.
- Different rules apply if a child or young person requires restraint. Legal advice should be sought on best practice.

Section 4

Bibliography

Legislation

Adults with Incapacity (Scotland) Act 2000. The Stationery Office, Edinburgh, 2000.

Children (Scotland) Act 1995. HMSO 1995.

College Statement on Covert Administration of Medicines *Psychiatric Bulletin* (2004) 28: 385-386.

Human Rights Act 1998. HMSO 1998.

Mental Health (Care and Treatment) (Scotland) Act 2003. HMSO 2003.

Mental Incapacity Act 2005, s20.

Regulation of Care (Scotland) Act 2001. The Stationery Office, Edinburgh, 2001.

Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, (SI 2002 No. 114). The Stationery Office, Edinburgh, 2001.

Other

B v Forsey 1988 SLT 572 (HL).

Management of patients with dementia. Scottish Intercollegiate Guidelines Network (SIGN), Edinburgh, 2006.

National Care Standards. National Care Standards Committee, Stationery Office, Edinburgh, 2001-2002.

Norman v Smith 1983 SCCR 100.

Position Statement on the Covert Administration of Medicines. Nursing and Midwifery Council (NMC), London, 2001.

Skinner v Robertson 1980 SLT (Sh Ct) 43.

National Care Standards care homes for people with mental health problems Scottish Executive December 2001 (revised March 2005), care standards 6.2, 17.

NHS Scotland *Managing health at work partnership network guidelines*, Scottish Executive 2004, guideline 6.

National Institute for Clinical Excellence, *The short-term management of disturbed/ violent behaviour in in-patient psychiatric settings and emergency departments* February 2005.

The latest information from the Scottish Executive is in *Safe care: consideration of the recommendations from the inquiry (England) into the death of David Bennett* Scottish Executive Health

Department 17 December 2004.

Report on incapable adults, para 2.53.

The European Convention on Human Rights, Fourth protocol, Article 2.

See *HL v UK* (2004) ECtHR 471 at para 116. (The 'Bournewood' case.)

R v. Ashworth Hospital Authority ex parte Munjaz (2005) UKHL 58.

Winterwerp v the Netherlands (1981) ECHR 7.

HL v UK (2004) ECtHR 471 at para 89.

R (Secretary of State for the Home Department) v Mental Health Review Tribunal (2002) EWCA Civ 1868; *R (G) v Mental Health Review Tribunal* (2004) EWHC 2193.

Bennion, *Statutory Interpretation*, 4th edition, section 174.

Medical ethics today BMA 2004.

Position statement on the covert administration of medicines August 2005.

Tablet crushing and the law Richard Griffith, the *Pharmaceutical Journal* (Vol 271) 19 July 2003.

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K Floor
Argyle House
3 Lady Lawson Street
Edinburgh
EH3 9SH

Service user and carer
freephone 0800 389 6809
Tel: 0131 222 6111
Fax: 0131 222 6112

enquiries@mwscot.org.uk

www.mwscot.org.uk

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